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LEADING ARTICLES

ENDOTHELIOMA OF THE PERITONEUM.

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One of the important contributions of abdominal surgery to the science of medicine is the knowledge of the great frequency of malignant conditions of the abdominal cavity. The study of ovarian growths has demonstrated that 20 per cent of them become malignant when permitted to pursue an uninterrupted course. The extension of the disease from the ovary and the uterus is a not infrequent cause of localized peritoneal infection. The extension from the uterus is much less marked than from the ovary. In the latter, there are many forms of growth, particularly the papillary, which rupture early, and when this occurs, leads to secondary implantation upon the surface of the peritoneum and produces a low grade form of peritonitis. This is associated with ascites. There is, however, a malignant disease which has its origin in the endothelium of the peritoneal cavity and is not infrequently found and mistaken for other conditions.

A patient with this disease generally gives a history of having suffered for some time with failing health, loss of strength, vague pains in the abdominal cavity, more or less interference with the action of the intestines, a certain amount of distension, frequent and irregular attacks of colic, loss of appetite and a sense of distress without being able to give an explanation for it. The symptoms will necessarily depend upon that portion of the peritoneum which is the special seat of the disease. With the involvement of the peritoneum, there frequently is experienced more or less pressure upon some portion of the intestine and interference with the peristaltic action. This leads to constipation, to intestinal distention and to a train of symptoms for which the patient is often treated for a length of time with the supposition that she is having intestinal indigestion. Later, the interference with the peritoneum leads to a low grade peritonitis and to the occurrence of ascites which may become very marked. Frequently the advent of the ascites is very rapid. I cannot better illustrate this condition than to recite the history of a case which has recently come under my observation:

A woman, 43 years of age., had been suffering for several months from distress and irregular colicky pains. The bowels had been rather constipated and she had a feeling as if there was some obstruction which interfered with the action of the intestine. The abdomen would at times be greatly distended, at others apparently but little more than normal. She had been subjected to treatment for intestinal indigestion and defective nutrition, until finally the abdomen became quite distended and was very tender to pressure. The patient was rapidly losing flesh and it was then thought that she might have some abdominal tumor.

When she came under my observation, the abdomen was distended to the size of a woman near full term. The entire abdomen was tender, so that she could not very readily yield to manipulation. The presence of ascites was recognized by the fluctuation and that it was free in the abdominal cavity was recognized by the line of dulness varying with the position of the patient. Vaginal examination disclosed the uterus rather fixed in the pelvis, no protrusion of the posterior vaginal wall as would ordinarily take place in ascites, but there was a certain amount of resistance in this situation, as if there was something intervening to prevent the pouching of the cavity from the pressure of the fluid. The

general appearance of the patient, the length of time which it had been in existence and the rapid increase of the abdominal distention with the marked emaciation led me to the conclusion that she probably had an endothelioma of the peritoneum. The only other possibility seemed to be that she might have had a papillary ovarian cyst which had ruptured and had a secondary implantation on the peritoneum.

The abdomen was opened, two gallons of dirty colored fluid evacuated and the broad ligaments found to have been the seat of an invasion of the peritoneum, which gave an appearance as if the surface was contracted, hardened and with a whitish appearance of the thickened surface. Looking down upon the peritoneum, it presented an appearance very much as if it had been burned. This invasion affected the broad ligaments so that the uterus was held pretty firmly in the pelvis. It extended over the bladder in front and over the anterior wall of the rectum posteriorly. As is usually to be expected in such conditions, the omentum was found to have been the receptacle as a secondary focus of the invasion and as a consequence was greatly enlarged, infiltrated and thickened.

With a view to delaying the progress of the disease as far as possible, the greater part of the omentum was tied off and cut away. The uterus, ovaries and tubes were removed. Gauze was packed into the vagina, holding up the intestines away from the infected area in the pelvis. It is not thought, of course, that such an operation would cure the condition, although experience does seem to indicate that in these cases, when the central area or focus of development has been removed, the subsequent progress of the disease is arrested, and in some rare cases, atrophy of the further infected tissue follows.

As has been mentioned, the progress of the disease will depend somewhat upon the portion of the peritoneum involved. I have seen the peritoneum over the entire course of the colon become involved, this disease leading to contraction and pressure upon the gut so that its caliber becomes greatly affected and the nutrition of the patient very rapidly influenced. One of the first cases of this kind that came under my observation was a woman who had an ovarian cyst and in whom the entire length of the colon from the cecum to the sigmoid was so contracted by the infiltration of its peritoneal surface that the finger could scarcely be passed through the canal.

The disease is a hopeless one, inasmuch as there is no operative procedure by which we can expect to remove the affected structures, nor is there any course of medication that seems to do more than palliate the state. In many cases the existence of the condition can be determined by palpation over the abdomen when there will be found points of thickening and infiltration, giving a sensation of increased resistance in certain areas. In others, as in the case first mentioned, it is impossible to be absolutely certain whether it is endothelioma or a ruptured papillary ovarian cyst with secondary implantation. In all these cases, however, the abdomen soon becomes so distended with fluid that it is desirable to draw it off in order to give the patient relief. In all cases of doubt, it is better to make an incision large enough for the introduction of the finger, so that the condition of the peritoneal cavity can be thus explored rather than use the trocar. Such an investigation determines the situation and enables the physician to appreciate and make known to the family the inefficacy of any plan of treatment for radical relief. Thus enlightened, the physician is enabled to employ measures for the comfort of his patient and avoids the resort to active measures for the treatment of a condition which is incapable of more than palliation.

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ABORTION.

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Abortion is the term applied to the expulsion or extraction of the product of conception before the period of viability. From the legal point of view, the fetus is assumed to be viable after the sixth month of gestation, that is to say, about 180 days after fecundation. Until recently, obstetricians hesitated to admit the viability of the fetus born during the seventh month, but since the introduction of the conveuse by Tarnier and the application of gavage to the feeding of infants born before term the clinical view coincides more or less with the legal assumption.

Abortion, especially criminal abortion, has become remarkably frequent and tends to increase. All obstetricians are agreed in calling attention to this increase in their wards. Various learned societies have taken up this matter which is fraught with such dire consequences for the nation. Criminal abortion is openly practised now-

adays. The address of disreputable places where the traffic is carried on by midwives and even medical practitioners, is passed on from one to another. The price varies according to the period of gestation.

One of the motives that underlie the frequency of criminal abortion is the ease with which it can be carried out. By this we mean that antiseptic procedures which have saved countless human lives have, by an unexpected repercussion, been instrumental in sacrificing innumerable little beings by lessening the risk attending criminal abortion. Formerly the prevalence of post-abortive infective complications acted as a check and made women think twice before incurring such grave dangers, but nowadays puerperal fever is less frequent and it is easier to treat, so that the terror which it inspires no longer exists.

Causes.—The other causes of abortion are classed under three heads, according to their origin, i.e., (1) from the father; (2) from the mother, and (3) from the ovum.

Paternal Causes.—Syphilis of course must be accorded a foremost place. The syphilitic virus is the cause of frequent abortions and we must always bear it in mind when no other explanation is forthcoming. As a rule in these cases abortion follows abortion until antisyphilitic treatment puts an end to the series.

Sexual excesses, fatigue and overwork, though not prohibitive of fecundation, appear to exert a diastrous influence on the development of the product of conception so that it is lacking in vitality and is unable to go on to term. The diatheses no doubt acts in much the same manner; tuberculosis, cancer, chronic intoxications, and extreme youthfulness of the father.

Maternal Causes.—These exert a predominating influence,especially when certain of them are associated with blemishes on the paternal side, e.g., syphilis, acoholism, etc. Sexual excesses provoke a sort of criminal traumatism of the uterus, giving rise to a state of chronic congestion predisposing to miscarriage during the first few weeks of marriage. Similary in some women the approach of the monthly period determines congestive phenomena in the gravid uterus which goes far to explain certain cases in which abortion takes place regularly at the menstrual period. Miscarriage in plethoric women and hemophilics belongs to this category.

All pyrexial diseases: variola, measles, scarlatina, typhoid fever, pneumonia, typhus, etc., may bring about abortion either as the result of hyperthermia and changes in the blood, or in consequence of changes in the placenta.

Certain other affections may also interfere with the course of gestation, notably gravid albuminuria and gravid nephritis; heart diseases and gravido cardiac troubles, chorea and incoercible vomiting which may, in some instances, necessitate artificial abortion.

Chronic constitutional maladies; tuberculosis, chloro-anemia, etc., bad hygiene conditions, underfeeding and habitual physical overstrain are all possible causes of interrupted gestation.

Other causes of abortion reside in the genital apparatus; retroversion and retroflexion of the uterus, the former giving rise to somewhat formidable accidents; uterine adhesions that constitute an obstacle to the normal development of the organ; fibroids, ovarian tumors, tumors of the Fallopian tubes, uterine prolapse, cancer of the cervix or body of the uterus, extensive lacerations of the cervical mucosa, ruptured perineum, etc. The uterus my be small, infantile—and unable to undergo the necessary development to accommodate the fetus or there may be a sort of instability or atony of the organ that culminates in the same result.

Consanguineous marriages, unduly frequent pregnancy, certain conditions of age, indeed even climate and altitude appear to create a predisposition to readily provoke abortion. We must not omit to mention sundry accidental causes, such as injury (blows on abdomen, falls, etc.,) powerful emotions, fright, etc.

Intoxications exert an unquestionable influence. Cigar makers and cooks are very liable to repeated abortion. We may also mention certain drugs which are credited with an ectopic action such as apiol, ergot, rue, savin, quinine, absinthe, iodide of potasisum, and permanganate of potash.

Among the many causes just enumerated the action of some is indubitable: syphilis, pyrexial diseases, gravidic albuminuria, traumatism, etc., while others only exert their influence in women, especially predisposed to abortion. In the latter case it is difficult to assign the degree of influence with which they should be credited.

Causes Connected with the Ovum.—The cause of the premature expulsion of the fetus will often be found in changes that have taken place in the ovum itself. They may be lesions of the placenta consequent upon decidual endometritis, or degeneration of the chorionic villi, or other

changes in the placenta. A frequent cause of abortion is the vicious insertion of the placenta. We may also mention the hydramnios, multiple pregnancy and death of the fetus.

Abortion may be provoked for therapeutical purposes under three conditions: incoercible vomiting, narrowing of the pelvis, and uterine retroversion.

Symptoms.—According to the stage of gestation, ovular abortion may occur during the first twenty days; embryonic abortion from the 29th to the 90th day; fetal abortion during the 4th, 5th and 6th months.

The miscarriage may take place suddenly; the woman loses a certain amount of blood all at once, she thinks that the menses have returned somewhat in excess, pains set in and expulsion may take place in a very short time.

As a rule there are premonitory signs, a sensation of lassitude, increased feeling of weight in the pelvis, obscure recurring contractions supervening at variable intervals, lumbar or crural pains with trifling hemorrhage. The premonitory signs vary with the period of gestation.

First Month.—Abortion during the first month often passes unnoticed presenting as it does the appearance of delayed menstrution. It is rarely diagnosed as such because the ovum is not discovered, although expelled intact. The women experience a few colicky pains, rather more than, or about the same as, at an ordinary period. The loss of blood is somewhat greater and clots are passed along with membranous debris. As no signs of pregnancy have as yet been perceived or are in any case very vague, as the loss of blood is but little in excess of an ordinary menstrual discharge, and as it coincides within a few days with the normal menstrual epoch, a first month's abortion usually passes unnoticed.

One fact, however, may be observed which is not without importance; as a rule ovular abortion passes unnoticed, and has no sequelae, but in criminal cases the woman may have been infected and the practitioner called in may find himself in a dilemma, since there is nothing to direct his attention to the uterus. He is naturally tempted to attribute the fever to some cause which he will seek to discover elsewhere than in the genital area, for the patient of course will not put him on the track. The case will present still further difficulty should infection have taken place independently of any actual voluntary traumatism. In one case which was thought to be typhoid fever, the real cause was only discovered at the autopsy. This source of error should be borne in mind in all cases of unexplained fever in women who may possibly have had a miscarriage.

Many cases of metritis owe their origin to ovular abortion. For the same reason the woman who thinks it merely a return of menstruation takes no precaution, does not go to bed, and, especially in married women, sexual relations are continued as usual. This habitual traumatism ultimately determines a condition of uterine congestion manifested by increased size of the organ, pain, a feeling of weight in the pelvis and lumbar region, the persistence of the discharge, the supervention of leucorrhea, and, ultimately, abortion.

Second Month.—Here the disturbances are more pronounced. The uterus has undergone a certain increase in size and is already hypertrophied, the signs of pregnancy are more marked and the woman is cognizant of her condition. Uterine contraction is stronger, more painful and the loss of blood will also be greater so that this group of symptoms suffices to establish the diagnosis of abortion.

As a rule the hemorrhage sets in first, preceding contraction. The hemorrhage detaches the ovum and uterine contraction carries it a step further. Little by little the ovum is pushed toward the cervix which partially opens, its orifice being blocked by clots, finally the ovum is expelled, membranes and all. The membranes however may be ruptured.

Abortion during the second month is more protracted in presence of a living fetus, the adhesions are tough and the hemorrhage more profuse. Uterine contractions occur first in these cases, causing detachment of the ovum and its expulsion. With a dead ovum expulsion takes place more rapidly and almost without loss of blood.

On vaginal examination the cervix is felt to be soft, the uterus displaced downwards and enlarged, the vaginal cul-de-sac distended and enlarged. If we watch the stages of abortion, we find that the cervix does not become affected, but half opens so as to allow the ovum to pass.

From the Third to the End of the Fourth Month.—At this stage the woman must be well aware of her condition for she will have missed several menstrual periods, the belly has become distended, the breasts have become larger and sundry nervous and digestive disturbances will have made their

appearance. In such patients a threatening abortion is maifested plainly. The earliest symptoms consist of lumbar and hypogastric pains of an intermittent character by expulsion of membranous shreds and bleeding. Uterine contraction here plays the principle role and extrudes the ovum into the crevical canal. Bleeding is variable in amount, sometimes it is trifling, in other cases abundant, or it may go on continuously until the symptoms subside or the ovum is expelled. The hemorrhage may come on in attacks which recur every few hours, or possibly, after several days interval, without any marked change in the os uteri. The patient is rendered more and more anemic in consequence of these repeated small losses which indeed may ultimately become grave by reason of their repetition.

On vaginal examination we find the uterus enlarged. Early in the case the os is felt to be patulous and soft and the canal is filled with clot, later on we can make out the ovum through the dilated cervix. After a variable period of time the membranous rupture and the abortion takes place in two stages: first the fetus, then the placenta. When the placenta is in its turn expelled, fragments of the decidua may remain in the uterus. It may happen that the after-birth is not completely detached, the cervix closing, and another "labor" accompanied by free bleeding is required for it to be extruded. This may be delayed for a time and herein lies the danger for as long as the partially detached placenta remains inside the uterus, the woman is exposed to the double risk of infection and hemorrhage.

Fifth and Sixth Months.—During the third and fourth months abortion enbloc is not common. Abortion resembles normal labor more and more, i.e., expulsion takes place in two stages, first the fetus, then the after-birth. True obliteration of the cervix takes place, the contractions are more powerful and more frequent and hemorrhage is less copious than during the third and fourth months.

Course, Duration, Complications and Prognosis.—From what precedes it will be seen that abortion does not run any fixed course and that its duration is uncertain. One may witness wide variations according to the stage of gestation and in individual cases. Under the influence of traumatism, fright, or violent emotion, abortion may take place very rapidly, the ovum being expelled almost at once, without the woman having been aware of it.

In other cases it drags on, expulsion not taking place for some days. The contractions come and go, the bleeding occurs and subsides, sometimes slight, sometimes more copious, according to the extent of the placental detachment. The ovum may be retained inside the uterine cavity for a variable period by solid resistent adhesions or owing to the feebleness of the uterine contraction. Less frequently the abortion is delayed because the detached ovum is detained in the crevical canal. This has very inappropriately been called secondary cervical pregnancy.

The complications of abortion are: (1) retention of after-birth; (2) hemorrhage; and (3) sepsis.

Placental retention may present several forms:

1.(a) Completely detached placenta. Under these circumstances the placenta may partially enter the cervical canal by which it is grasped, or it may remain inside the uterine cavity, giving rise to hemorrhage or infection. As a general rule dull pains supervene that bring about its expulsion, or it may break down and be eliminated in fragments. Being deprived of its relations with the uterus, the after-birth undergoes decomposition.

(b) Completely Detached Placenta. Here the situation is more complicated since expulsion may be delayed from twenty to thirty days. The os closes, shutting in the after-birth, the woman loses a little blood-stained fluid and matters come to a full stop. After a variable period, a few days to several weeks, the placenta becomes detached, this being announced by a return of the bleeding. Uterine contractions take place and expulsion is effected without the woman suffering in any way from the protracted retention. The placenta will be found to have undergone fatty degeneration, but it is not otherwise changed, it has no odor and does not present any signs of putrefaction.

According to some authors the after-birth as such may not be expelled at all, disappearing by a process of absorption, or coming away imperceptibly.

c. Partially Detached Placenta. These cases are particularly delicate because they expose one to a double complication, hemorrhage on the one hand, infection on the other. The prognosis depends on the skill of the obstetrician and the measure he employs. It is easy to understand that the partially disinterested placenta, filling as it does the uterine cavity, paves the way to continuation of the hemorrhage while the detached portion, being deprived of its vas-

cular connection, may undergo putrefaction and cause septicemia. Sometimes fragments of placenta remain adherent giving rise to metritis. Under these circumstances it is usually advisable to abstain from pulling on the partially detached placenta in order not to increase the hemorrhage unless we have made up our minds to provoke artificial delivery and curette the uterus.

2. Hemorrhage.—Hemorrhage, which is inseparable from abortion, may, by its copiousness and its repetition, engender a grave situation especially in weak, debilitated persons. It may be accompanied by serious constitutional symptoms and signs of acute anemia; noises in the ears, pallor of the skin disturbances of the sight, small thready pulse, and syncope. We must not allow ourselves to be unduly alarmed by this bleeding, especially if the placenta becomes detached and is followed by constitutional symptoms which are more alarming than dangerous. Nevertheless we must be prepared to act according to circumstances. The amount of bleeding varies and the date of its appearance varies likewise. It may occur coincidently with the detachment of the ovum or when the placenta becomes disinserted, or it may be delayed in cases of placental retention until after the expulsion of the fetus. We must as far as possible control the hemorrhage since it weakens the patient predisposed to infection.

3. Sepsis.—It is, as a matter of fact, especially in debilitated patients that sepsis mostly occurs. In such subjects special care must be devoted to antisepsis and asepsis and the most scrupulous cleanliness should be insisted upon. The physician should be particularly on the alert when he finds himself confronted by a case of partially detached placenta which so readily undergoes decomposition, or persistent bleeding with partially dilated cervix. These two conditions specially favor septic infection.

Fetor of the lochia may mean infection, which is followed by a rise of temperature with shivering and abdominal pain. These symptoms generally indicate the invasion of pathogenic organism.

When proper antiseptic measures have been taken, and when the woman is properly looked after, the abortion mortality in hospitals does not exceed 0.81 per cent, while it is 27.3 per cent in women in whom abortion has taken place at home. The prognosis is especially grave in cases of criminal abortion because the operator's fingers and instruments are septic more often than not.

We will not discuss the puerperal sequelae, the diagnosis and the course to pursue according to the particular circumstances and conditions.

The discharge that accompanies miscarriage varies according to the more or less advanced period of gestation, whether the abortion takes place en bloc or the placenta be retained more or less completely in the uterine cavity. During the first two months the discharge is trifling and if the patient be properly attended, it will cease with a few days rest. Under the ordinary conditions of life, many women pursue their occpuations without troubling about it at all. At the end of the third month and during the fourth month, abortion takes place in two stages and the bleeding is more abundant. Debris of decidua, membranes and placenta are mixed with lochia turning the latter a chocolate color and a syrupy consistence. We must carefully note the odor of this discharge, taking the temperature every day and enforcing rigorous aseptic and antiseptic precautions.

The secretion of milk hardly occurs before the third month. When the fetus dies there is a rise of milk which recurs in a feeble sort of way on the expulsion of the ovum or rather two or three days after.

The uterus not being enlarged, involution takes place rapidly after abortion, especially if the patient goes to bed and takes proper care of herself. More or less protracted retention of the placenta, however is a comon cause of subinvolution, and if the woman resumes her occupations too soon the uterus is apt to remain enlarged and congested. Anything that delays uterine involution favors metritis.

In most cases it is easy to recognize impending abortion. The woman knows herself to be pregnant, the signs of pregnancy are obvious; the discharge of blood, the painful contractions, the softening of the cervix, the enlargement of the uterus, the presence of clots in the half dilated uteri, the possibility of feeling the ovum inside the cervix, etc., are symptoms of threatening abortion, indeed we can often determine the cause thereof. It does, however, sometimes happen, especially during the first two months, when it is impossible to be quite certain of the existence of pregnancy, that we may hesitate whether it is a miscarriage or whether the symptoms are not due to some other cause. The diagnosis is all the more delicate, seeing as yet, there is no incontrovertible sign of

pregnancy and the usual sympathetic indications are wanting. This is often the case in women who menstruate irregularly, in women who fall pregnant during a period of amenorrhea,or during lactation, and who consqeuently cannot attach any particular importance to the absence of the flow. Then too, examination may be rendered extremely difficult by the existence of a thick layer of subcutaneous abdominal fat; or we may have to deal with women who are approaching the menopause and entertain no suspicion of pregnancy. It is unnecessary to recapitulate the signs of pregnancy and its diagnosis at the various periods, but it is important.

It sometimes happens that a woman who is merely dysmenorrhoric believes herself pregnant so that when the period returns it is attributed to a miscarriage. In abortion, the bleeding usually precedes uterine contraction, the cervix is partially dilated and soft and clots are plentiful. In dysmenorrhea the pain precedes the blood-stained discharge, the os uteri is closed,the uterus is small and there is no softening of the vaginal cervix.

The empty uterus in retroflexion may lead us to suspect pregnancy, but the state of the cervix, the persistence of the menstruation, the absence of the elasticity peculiar to the gravid uterus, and the absence of any sympathetic manifestation will enable us to discard the idea of miscarriage. Nevertheless we may find considerable difficulty in cases in which there is concomitant metritis or fibroids, for in such cases the uterus is often enlarged, the cervix more or less softened, and there is some bleeding so that a certain diagnosis may be quite impossible for the time being at any rate.

We must not mistake for threatening abortion various painful manifestations that may suprevene in a pregnant woman, such as hepatic colic, nephritic colic, flatulent distention from constipation, the pain of appendicitis, hemorrhoids, etc.

Some bloody discharges do not come from the uterus and have nothing in common with miscarriage, indeed even a perfunctory examination may suffice to show that the blood comes from the anus (hemorrhoids) or from an organic lesion of the cervix or vagina, rupture of the varicose vein or local traumatism.

Has Abortion Already Taken Place.— Though this may appear to be a very simple question, it is often far from easy to answer, indeed, we may not be able to decide. During the first week's flow the ovum is so small that in many instances it escapes notice. Most women think it is merely the return of the menstruation and they attribute the clots, colicky pain and unusual abundance of the flow, merely to the delay. It may happen, however, that everything has been thrown away before the physician appears on the scene, or the patient, feeling constrained to go to the closet, has there passed a formless mass without its attracting her attention. The practitioner under these circumstances may be much embarrassed in making up his mind whether or not the miscarriage has actually taken place; the difficulty is enhanced should the fetus be dead and be retained for a variable period in the uterine cavity. The subsidence of the sympathetic phenomena of pregnancy, a slight rise of milk and a diminution in size of the uterus may lead us to think that everything has come away, whereas the withered, shrivelled ovum is still lying in the uterine cavity.

Even when the practitioner has everything before him it is often difficult during the first five or six weeks to form an opinion owing to the small size of the ovum. We must examine the clots and debris very carefully under a fine stream of water looking out for chorion villi and if necessary it may be examined under the microscope. In medico-legal cases, it is advisable not to formulate an opinion without substantial reasons for asserting that abortion has taken place and the greatest prudence and circumspection should characterize reports drawn up for the tribunals.

Sometimes clots accumulate between the external walls and the ovum in consequence of inter-placental hemorrhages. These clots are expelled bit by bit in the form of a reddish brown discharge which persists for rather a long time. This does not constitute abortion because the ovum may still be growing.

It is not always easy to decide whether the abortion is complete. Examination of the fetus and placenta will afford sufficient information,but it often happens that part of the membranes and clots have been thrown away, so we are left in doubt. We may however conclude that the placenta in whole or in part has been retained when the uterus remains big and when we detect parts of the after-birth within the uterus.

In presence of a miscarriage we must endeavor to ascertain its cause by close questioning in view of the prophylactic treatment to be adopted to prevent its recurrence in the event of subsequent pregnancy. But too often the abortion is the result of a criminal operation, and the women in this case will not admit a possible miscarriage or of

having had an abortion done. The other three principle causes of abortion are syphilis, albuminuria and vicious insertion of the placenta. In abortion due to syphilis the fetus is born dead and macerated and there is very often a history of previous miscarriages. We may discover signs of syphilis in the father or mother or both. If it be due to albuminuria the placenta presents changes of a special kind with patches of hemorrhages, the urine contains albumen and there are symptoms of nephritis. In vicious insertion of the placenta we get repeated attacks of bleeding and when we examine the membranes it is seen that the placenta was inserted into the inferior segment. Should none of these causes be discoverable, we must go over the causes enumerated in connection with the etiology of abortion.

Preventive Treatment.—The pregnant woman should be subjected to special rules of hygiene, she should avoid anything jeopardizing the life of the product of conception. So far as her social position and duties allow, she should take plenty of rest without however shutting herself up at home, fresh air and exercise being indispensable to her welfare. She should abstain from fatiguing exertion, hurrying and frequent travelling, these being the determining causes in many cases of abortion. Sexual connection should be infrequent. Pregnant women should wear loose clothing so that nothing may hinder the development of the uterus. Dancing, horseback exercise and swimming should be forbidden. Short baths, not too hot, are permissible, but vaginal injections should be very prudently employed unless there be copious leucorrhea. The vulva on the other hand should be frequently washed. Constipation should be overcome by the methodical use of mild laxatives, enemata, etc. We need not insist on the various details that belong to the hygiene of pregnancy merely observing that our precautions should be enforced all the more strictly when there is a history of previous abortions. It is sometimes necessary to keep the patient on her back on a couch throughout gestation.

Preventive medication will be directed more particularly to the determining causes of the abortion. Syphilis should be treated from the very onset of pregnancy and this applies also to mercurialism, plumbism, etc. When the pregnant woman is living under unfavorable conditions of health, hygiene, ventilation, etc., we must treat everything that may interfere with the course of gestation.

These precautions having been taken the practitioner will not be exposed to reproach whatever happens. Should symptoms of threatening abortion supervene he will follow the course that has been laid down.

Threatening Abortion.—There may be pain and bleeding although the ovum is still intact, and although there may be no other accident (infection, fever, intense anemia from repeated hemorrhages) no signs of death of the fetus (disappearance of the sympathetic features of pregnancy, rise of milk) still it does not follow that abortion is inevitable. Under these conditions we must do our best to stop it. The woman is to be kept completely at rest with the head low and the plevis slightly raised.

Opium may be given in full doses. The rectum having been cleared out an enema may be given containing 20 to 30 drops of liquid extract of opium in four fluid ounces of water. This may be repeated several times a day to the extent of 100 drops of the drug in 24 hours. Under this treatment the contractions often diminish in frequency and intensity, the flow is reduced and the signs of impending abortion gradually clear up. Choral may be combined with laudanum to enhance its effects or we may prescribe tincture of viburnum prunefolium in ten-drop doses, five or six tims in 24 hours, as an adjuvant to the other treatment.

When matters are urgent injections of morphine are preferable to laudanum for its effects are prompter. Beginning with a sixth of a grain this dose may be repeated, if the patient bears it well, once or twice in the course of the day.

Throughout the case we must abstain from vaginal examination as far as possible in order to provoke uterine contraction and this remark applies equally to very hot injections and to vaginal injections in general, except for the purpose of cleansing the parts. In such case the temperature of the water should not exceed 99 deg. F.,and the douche need not be raised more than a couple of feet above the level of the head.

Abortion is Inevitable.—In spite of all the precautions we have enumerated the symptoms of abortion may persist, the bleeding continue,the contractions recur or the membranes may rupture, or the fetus may succumb or the bleeding may be so copious and the ovum so far down that we can no longer hope to arrest the process. Under these circumstances,we must, as in ordinary labor, carefully disinfect the external genitals, frequently washing the vulva, administer antiseptic injections which will check the hemorrhage and

cleanse the vaginal canal. An antiseptic compress is applied to the vulvar aperature and then we can await events. Several things may happen.

The ovum may be infected in spite of its being intact. Plug the vagina in order to expedite expulsion and if nothing happens in the course of the next few hours anesthetize the patient, disinfect the genital tract, practice gradual dilatation of the cervix and clear out the uterus and abdomino-vaginal expression. When the ovum is ruptured and the fetus expelled our conduct will depend upon circumstances.

In the presence of copious and repeated hemorrhage we may pack the vagina as this is both hemostatic and stimulates uterine contraction, thus promoting the complete detachment of the placenta and its expulsion. Against this course it is objected that often the packing is badly done, that it is very uncomfortable for the woman, that it is ineffectual in that it does not prevent the hemorrhage going on the inside while it dams back the clots and opens the door to infection.

To overcome these drawbacks it is well to pack the uterus itself with antiseptic gauze, and unquestionably this procedure may render great service in urgent cases in which the woman is too weak to bear digital curettage, when in fact it is necessary to improve her general condition before doing anything. Except under these circumstances the procedure is best avoided for the plugs may be the means of conveying infection. Curettage is preferable for it arrests the hemorrhage by emptying the uterus and affords an assurance against further anxiety. This last point is important because the practitioner may be living at a distance with no one at hand to replace him at the bedside. When the placenta is partially detached and is extruded through the os uteri, or has actually passed into the vagina, we may be tempted to try and withdraw it with the fingers or forceps. This must not be attempted unless we are prepared to do a curettement, as the placenta may be torn, thus increasing the hemorrhage to such an extent as to prove dangerous.

There may be retention of the placenta after abortion and expulsion of the fetus without any subsequent hemorrhage or infection, and when this is the case it is better to wait. In most instances the contractions return in the course of a few hours. Ultimately the after-birth comes away with little or no bleeding and the matter is at an end.

The next question is how long we should wait in cases of placental retention unaccompanied by accidents. This is somewhat uncertain. The placenta has been shown to remain for several weeks inside the uterus without undergoing decomposition and has ultimately been expelled. We must therefore let circumstances decide for us. If we decide to await events we must keep close watch on the patient, the temperature should be taken every few hours. Should symptoms of infection show themselves, the uterus should be emptied under strict antiseptic precautions.

In cases in which there is neither bleeding nor fever it would be imprudent to leave the placenta in situ for more than four or five days. To delay longer would only to add to the chances of infection, hemorrhage, and the transformation of the placenta into a polypus or deciduoma, etc. We may add that in cases of dead, macerated fetus, double or multiple abortion, the placenta ought to be extracted forthwith.

There are two ways of extracting the retained placenta: instrumental curettage and digital curettage. Each method has its advocates and its adversaries. Some prefer the curette during the first two months because they say, the uterus is small and its walls are thick and resisting enough to obviate any risk of perforating the uterus. They urge that it is easier to introduce the curette without having to dilate the cervix and without inflicting any further injury, skillfully handled it does better work than the finger; furthermore the instrument is cleaner and easier to sterilize than the finger.

If the placenta be in a state of putrefaction the finger is contaminated and may disseminate the germs all over the uterine mucosa; these dangers are reduced to a minimum when the curette is employed. Others assert that the curette is a blind instrument which exposes the patient to the risk of perforation, which does not afford any trustworthy information as to whether or not everything has been removed, and we may after all leave placenta debris in the uterus. Assuredly in inexperienced hands the curette may prove a dangerous instrument either because the practitioner lacks the courage to push the curette until he gets the unmistakable "uterine squeak," or because he goes too far, and passes the instrument through the friable uterus into the peritoneal cavity.

Some obstetricians advise against instrumental curettage. Of course, when for any reason, digital curettage is not practicable we must employ the curette. Whichever

method is adopted antiseptic precautions are necessary.

Having said this much as to the different procedures, intervention is formally indicated.

1. When the placenta has been retained beyond the generally approved limits (four to five days).

2. When the symptoms of infection make their appearance or when there is serious hemorrhage, either on account of its abundance, its persistence, or its recurrence.

Medical Defense in New York.—From September, 1900, to January, 1910, the Medical Society of the State of New York has taken charge of 250 cases of threatened prosecution of members for alleged malpractice; 138 have been actually tried in court, not one finally lost. In one case a verdict was returned against the member, but a new trial has been asked for and a favorable result is expected.

The Prevalence of Venereal Disease Among Recently Arrived Immigrants (With special reference to International Infection.)—Dr. A. L. Wolbarst has a very interesting paper on the above subject in the N. Y. Medical Journal (October 16, 1909). The patients he had to deal with are practically all immigrants from Russia and adjacent countries, of the Jewish race. While the percentage of venereal infection is quite low, still it is large enough to excite alarm in view of the danger of the transmission of the disease to the innocent wife. Dr. Wolbarst thus summarizes his paper: 1 "About one-third of one per cent of all the male patients at the Beth Israel Hospital Dispensary, nearly all recently arrived immigrants, suffer from venereal disease, acquired after their arrival in this country. 2. Of 210 patients in whom the histories were carefully taken, 114 were single (54 per cent) and 96 (46 per cent) were married; of the married men, 35 (16 per cent) were living with their wives in this city; 61 (30 per cent) had wives in Europe ("celibate husbands"). 3. Most of the patients were infected after their first year in the United States; 44 (72 per cent) were infected during the second, third and fourth years. 4. It thus appears that if these men were enabled to bring their wives to this country before the second year, the greatest danger from venereal infection might be avoided. Possibly the conditions are serious enough to warrant such assistance being rendered by organized forces having the welfare of immigrants at heart."

CLINICAL LECTURE

GONORRHEAL ARTHRITIS.

JOHN V. SHOEMAKER, M. D., LL. D.

PHILADELPHIA.

Professor of Materia Medica, Therapeutics, Clinical Medicine and Diseases of the Skin in the Medico-Chirurgical College and Hospital, Philadelphia.

Gentlemen: The patient before you this morning suffers from a disease more common to the male than the female sex.

The patient S. W., male, white; age 59 years; occupation car builder.

Family History.—He has no knowledge of his grandparents. Father died with typhoid fever at the age of 45. Mother died of "old age." He is the father of eleven children—five boys and six girls. Six of his children are dead—five of them died at birth while one died at the age of 27 of edema of the lungs. The remaining children are well. He has two sisters and one brother living and apparently in good health. One of his brothers is dead as a result of an accident. His aunts are well and living, but his uncles died as a result of pusmonary tuberculosis and heart disease respectively.

Previous Personal History.—Patient has had the usual diseases of childhood and walking typhoid fever at the age of 14 years. Other than these attacks he was always very healthy. He had gonorrhea four or five months ago, which he says readily responded to treatment. At the age of 21 he met with an accident in which he hurt his ankle and was compelled to use a crutch for a period of thirteen months.

Social History.—Married at the age of 25; wife died at the age of 52 from carcinoma of the stomach.

He is in the habit of taking a glass or two of beer daily. He drinks tea or coffee—two cups at each meal. Smokes and chews tobacco, excessively.

Present Illness.—First noted December 24, 1908, while at work he began to feel badly, and was finally compelled to go home. The chief symptoms experienced at that time were nausea, malaise, anorexia and pain over his entire body. He then bought ten cents worth of whiskey and drank it. Then he took a bath and went to bed. After lying for about five hours he felt worse and finally applied for medical treatment. While descending the porch-stepsof the doctor's office he felt pains in the sole of his foot. This was followed immediately by extreme soreness which extended up the right leg and involved both hands compelling him to remain in bed

Later the pain extended down into the left leg; was sharp and lancinating in character. His knees swelled up the next day after the attack began and have been swollen ever since. The knee joints are still very painful on motion, and around the left knee there is considerable exudate which fluctuates on palpation.

Diagnosis.—We diagnose this case as gonorrheal arthritis from the history of gonorrheal infection, soon followed by an inflamed joint, the violent pains, swelling of the joint with the extension along the course of the tendons and his moderate fever.

Gonorrheal arthritis is an affection in which the symptoms are identical with those of rheumatism, and they must therefore be differentiated.

For your convenience we will place a tabulated differential diagnosis on the blackboard:

Gonorrheal Arthritis.	Acute Articular Rheumatism.
1. History of gonorrhea	1. History of exposure to cold, etc.
5. One or two joints attacked.	2. Many joints attacked.
3. Pain more intense.	3. Pains not so intense.
4. Condition is obstinate.	4. Disappears readily under treatment.
5. No profuse sweats.	5. Copious sweating.
6. Temp. moderate.	6. Temp. high.

Etiology.—This affection is specific synovitis caused by the gonococcus. It may develop at any period during the course of gleet. The symptoms usually appear after six to ten days after the discharge is seen and sometimes they appear much later, as much as four or five months after the discharge.

Pathology.—The morbid changes that take place in this affection are first, a hyperemia followed by all the other phenomena peculiar to an inflammatory process, namely, exudation into the cavity of the joint. Pus is rarely present. Occasionally the inflammatory process is periarticular (gonorrheal tenosynovitis). The exudate invades the tissues around the joint including the sheaths of the tendons and pus has been found in these sheaths. The presence of gonococci has been demonstrated in the effusion, but this is not generally the case. The joint may become stiff and swollen, thus changing the shape and affecting the mobility of the joint.

Endocarditis has been reported as complication of gonorrheal arthritis. Pericarditis, pleurisy, iritis, and sclerotitis may also complicate this affection.

Treatment.—Rest in bed with immobilization of the parts is of paramount importance. Whenever there is an effusion as in this case local irrritant agents are serviceable and should be employed to the extent of blistering the parts. The remedy I prefer is unguentum hydrargyri nitratis applied freely and the parts covered with oiled silk and bandaged. The thermo-cautery is likewise valuable.

Internally mercury is probably the very best remedy, combined as follows:

℞ Hydrargyri cum creta.....3ss
Pepsini .....gr. xl
Phenylis salicylatis 3iss
Misce. Fiant capsulae No. xx.
Signa. One capsule four times daily.

This capsule physiologically acts as an alterative and also as a valuable antirheumatic without disturbing digestion. It hastens elimination by virtue of its action upon the liver, intestines and kidneys.

Salicin in five grain doses every three hours relieves pain and reduces abnormal temperature.

Syrupus ferri iodidi is another valuable altrative and has given me good results in many patients suffering from this disease. It probably hastens absorption of the exudate in this disease better than many other preparations.

The diet must be liquid consisting chiefly of milk and broths. Massage should be employed as soon as the pain is relieved to reduce the effusion and the swelling, and at the same time restore the joints to their natural motility.

Points Regarding the Census.—The census begins April 15 and must be completed in two weeks in cities and in thirty days in all other areas. The enumerators will wear a badge inscribed "United States Census, 1910." The law requires every adult person to furnish the prescribed information, but also provides that it shall be treated confidentially, so that no injury can come to any person from answering the questions. The president has issued a proclamation, calling on all citizens to co-operate with the census and assuring them that it has nothing to do with taxation, army or jury service, compulsory school attendance, regulation of immigration, or enforcement of any law, and that no one can be injured by answering the inquiries. It is of the utmost importance that the census of population and agriculture in this state be complete and correct. Therefore every person should promptly, accurately, and completely answer the census questions asked by the enumerators.

THE MEDICAL FORTNIGHTLY

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EDITORIAL

The Local Medical-College Situation.

It would be a novel experience for the St. Louis profession to find itself with no speculation on hand as to what is to be done with the local medical schools; the situation is always one of mingled pessimism and optimism with, during the past decade, constantly increasing optimism. The importance of St. Louis as an educational center has always been great, greater, in fact, in medicine than in any other line; but there are few people, even here at home, who really appreciate the tremendous strides which medical education has taken these recent years. The number of schools has rapidly decreased and the standard of medical education has been so raised as to make the student of the present day a very different man from those of a quarter of a century and less back. Of course the ideal has not been reached in even the best of the local schools, but it appears to be coming. We still hear of dissentions and disasters in connection with one or two of our schools, and it is commonly predicted that they will soon go the way of others which are gone and well-nigh forgotten, this will certainly happen if they do not heed the signs of the times and get themselves in a form to compete with those institutions which have gotten into the line of progress. We believe that there is still a useful place for the school which offers professional education to those who have not had collegiate training, a baculaureate degree is an exceedingly desirable thing, but it is not always an index to the possession of the common sense which is an essential to the successful practice of medicine, nor does a degree always mean that its possessor is practically educated. We would like to see right here in St. Louis as a competitor of the two great university schools one good school which would impart a thoroughly practical medical education to the great army of capable men who cannot consider a college education and to whom "the equivalent of a high school education" is sometimes an obstacle to be surmounted.

But we do rejoice in our two university schools and in the rumors of the past fortnight relative to the Medical Department of Washington University. In its every department and interest the development of this university has been one of the most remarkable of the many surprising and even startling evidences of growth and increased usefulness which have characterized St. Louis in many lines during recent years. The transfer of the collegiate and some other departments to the new buildings in the west-central part of the city six years ago has been followed in quick succession by the strengthening of departments, erection of new buildings and inauguration of new interests. Changes in plan and policy have had their effect on the medical school along with the rest to its great betterment. The latest reports have it that the medical school is to occupy the center of the stage in the matter of immediate change, that an endowment of such considerable proportions is to be available as to make it possible to at once place the school in the class with Johns-Hopkins, Harvard and the one or two others. Naturally there is some reticence on the part of the authorities of the university about confirming or denying the report, but there is so much of circumstantial evidence obtainable as to make all seem probable and possible. Its reality will mean great things for St. Louis, for medical education and for the St. Louis profession.

Byron Robinson.

Byron Robinson is dead. It has rarely been our duty to record a more regrettable fact. There can be few of our readers who do not feel that they knew Byron Robinson. His contributions to the Fortnightly and the medical press generally were frequent and of so deep and scholarly a character as to tell of the anatomist and surgeon give but faint idea of the human side of the man himself. Investigators are not, as a rule, practical men, their work has seldom combined with it an activity in every day application, as was the case with Bryon Robinson in his work. Among Americans he was easily the foremost of our anatomical investigators, and his discoveries were

nore numerous than those of any other; his name will live for all time in anatomic nomenclature. But he was a surgeon as well, and a brilliant and tireless one at that. He was as well a very human man who looked for, and usually found, the good that was in each of his associates; no student under him ever displayed interest in his subject without finding in Byron Robinson an encouraging friend who would place at his command every available opportunity for advancement. If one were looking for faults

DR. BYRON ROBINSON.

in Byron Robinson we doubt if other could be found than the fact that he did not know how to rest or take recreation; his work was his recreation and it is a mystery how he could accomplish so much and not have reached his limit even earlier than he did. He died young, he was in the early fifties, but he died full of years if we are to judge the length of life by accomplishment. In so far as we have been able to learn the exact cause of his death was not determined; some knowledge of his activities for several years leads us to surmise that we have discovered it. He had accomplished a life's work and the curtain was drawn.

Byron Robinson worked for the very love of work, and never for the hope of reward or glory; he may have felt the lack of appreciation and recognition on the part of his fellow-workers in the same field, but if he did,it in no sense lessened his enthusiasm in his work or his faith in his results. Our own appreciation of Byron Robinson has made us jealous for him of greater recognition from the American profession; his experience exemplified in a high degree the truth of the prophet with but partial honor in his own country. Many, many Americans did appreciate his greatness, but he did not live to see the general recognition which, we believe, will be given him and which his work honestly merited. That he might not have while still living seen the honors which are to be his in fullness adds to the sadness we feel over his untimely death.

Induced Hyperemia in Treatment.

There continues to be a rather rich literature on the employment of Bier's method of induced hyperemia in the treatment of various conditions, much of which fails to be of practical value in that it does not go sufficiently into details as to indications and methods of application. A limited experience has not made us so enthusiastic over the method as are many who are employing it more extensively. Notable among those who are finding in it a uniformly reliable agent is Daniel who states* that he has been it in his own practice so uniformly successful with this method of treatment that the unsatisfactory results often following its adoption when delegated to house surgeons and practitioners must be due to want of familiarity with the technic and peculiarities attendant upon this plan of treatment. As the success of the treatment practically depends upon ascertaining first the exact degree of hyperemia suited to each individual case, secondly the maximum duration of time the hyperemia should be maintained, it follows that a very close watch must be kept upon every case during the earlier applications of the bandage or suction glass—the failure to observe the first effects of the treatment on the individual case is the most usual cause of non-success. The second great cause of failure depends upon the almost universal belief in the shibboleth that the vascular phenomena of inflammation are evil, and anything which tends to produce or increase any of the signs of inflammation cannot be good. Unfortun-

*Gaillard's Southern Medicine, VII, 1909.

ately, pathologists still include in these phenomena the stages of stasis and thrombosis, and thus prepetuate this erroneous view that all the stages of inflammation are evil and to be combated at all costs. On the contrary, the first three stages are most essential, and without them resistance to infection is absent; they should be styled hyperemia, and are manifest clinically by redness, heat, swelling, and almost every method of treatment which produces these clinical signs is used successfully in the treatment of disease—fomentations, blisters, friction, massage movements.

The four methods of treatment adopted by Bier, when properly applied, result in this trio of symptoms, and without going further into the question whether the congestion ultimately attained by the bandage and suction glass is, or is not arterial, stasis in the blood-flow must never result. The modes of application are: 1. By graduated constriction by means of an elastic bandage. 2. By intermittent suction of specially constructed cupping glasses. 3. By the use of hot dry air. 4. By Kuhn's mask (in pulmonary phthisis). The author devotes twelve pages to the indications for use, the apparatus, and the technic.

After stating the statistics as to the mortality from different diseases in Panama, at different periods, Dr. Osler said that in 1908 the combined tropical diseases, malaria, dysentery and beri-beri, killed fewer there than the two great killing diseases of the temperate zone, pneumonia and tuberculosis.

The new buildings of McGill University, erected to replace those which were destroyed by fire three years ago, are now approaching completion. The medical faculty has decided to hold the next annual convocation, for the conferring of degrees in medicine, in the new building and to signalize the event by carrying out a long contemplated plan for a reunion of all her graduates June 6 and 7, 1910.

Kitasato has published an article on tuberculosis in Japan, in a German journal of hygiene, showing that tuberculosis is on the increase in this country. The fact that there are practically no cows in Japan, and that tuberculosis is as prevalent there as here, should furnish comment on the hysteria that is now asserting that 15 per cent of our human tuberculosis is from cattle. Perhaps one-tenth of that amount would be nearer correct.

CORRESPONDENCE

THE BIRTHPLACE OF BILLROTH.

191 Dean Street, Brooklyn, N. Y.,
March 29, 1910.

Editor Medical Fortnightly:

All well-informed students know that history is slippery ground, and that censorious critics have said many hard things about its inaccuracy. A slip of mine, which Dr. H. Stern kindly points out, is a forcible reminder of how easy it is to err in such matters. In my letter on "Scandia to Gallia Cisalpina," Bergen in Norway has been credited with being the birthplace of Billroth. The impression received from my readings, prior to visiting that place, are responsible for the statement which now seems to be an error, Billroth was born in Bergen, on the Island of Rugen, in the Baltic, not far from Stralsund, the birthplace of the Swedish chemist Scheele. In my letter reference should have been made to Billroth and to his accomplished teacher, Langenbeck, as part of the description of Berlin. The great prominence of Norway's Bergen and the relative obscurity of other Bergens appears to have puzzled a number of authors. In two histories, just consulted, the birthplace is given as "Bergen" without regard to which of many Bergens is meant. Naturally readers fail to think of the Bergens of Belgium, The Netherlands, New York, New Jersey, or the three Bergens in Germany, and do think of the one best known. The correction is timely and may save future writers from the same mistake.

Very sincerely,

R. G. ECCLES.

Dr. J. L. Crook, of Jackson, Tenn., president of Tennessee Medical Society, has been appointed by the Rockefeller Commission to take charge of the work of placing the subject of hookworm disease directly before the organized medical profession of the Southern States. His work will be done entirely by correspondence from his office.

Use No Pastes in Cancer of the Mouth and Lips.—I must decry the use of all cancer pastes, which sometimes successfully cause a slough of the growth and of the surrounding tissue if the growth be small, but often only irritate the deeper cells of the growth, causing them to develop with redoubled activity and starting the infiltration of cancerous cells, which will finally elude all treatment.—Dr. Ernest Laplace.

SOCIETY PROCEEDINGS

MEDICAL SOCIETY OF THE MISSOURI VALLEY.

Twenty-second Semi-Annual Meeting, held at Omaha, March 17-18, 1910.

The President Dr. A. B. Somers, Omaha, in the chair.

Psychotherapy in Relation to the General Practice of Medicine and Surgery.—Dr. Henry S. Munro, Omaha, discussed psychotherapy in the field of preventive medicine; in the domain of psycho-physiologic therapeutics; as an adjunct in the treatment of acute diseases; as an aid to surgery in the treatment of chronic diseases, and in relation to the prevalent professional psychasthenia.

DISCUSSION.

Dr. C. R. Woodson, St. Joseph, Mo.: The physician who possesses the power to entertain, to divert, and to inspire confidence, who can honestly set forth facts and take an individual's mind off of an object of worry, or who can influence him along these lines, is the best psychotherapist.

Dr. A. S. von Mansfelde, Ashland, Neb.: I do not believe that a man can be educated to become a successful psychotherapist. The successful psychotherapist is born, not made.

Dr. R. Willman, St. Joseph, Mo.: Instruction and investigation, if properly given and carried out, will do much toward mitigating and annihilating false mind-healing. Psychotherapy is not new, but physicians have not practiced it to the extent they should have done.

Dr. S. Grover Burnett, Kansas City, Mo.: Before attempting to administer psychotherapy, the physician ought to make a diagnosis. Without a diagnosis, he had better not say or do anything. If a physician has not diagnosed correctly the ailment of a patient, he is just as likely to give pathologic suggestions as he is to give physiologic ones. Babinski says that functional conditions, such as so-called hysteria, are caused by suggestion and relieved by persuasion. While all members of the profession are not ready to accept that statement, the more one studies it the more clearly he sees the basis for it.

Dr. O. Beverly Campbell, St. Joseph, Mo.: I do not believe that 75 per cent of the people are neurasthenics. I have observed that as I am becoming a better diagnostician from day to day I am able to find pathologic conditions as causes in more cases of neurasthenia than I ever did before. I believe that confirmed neurasthenics need suggestion. They need to be told some things they do not know. If they are in fear of a great calamity, if they believe they are in a serious condition, and the physician can diagnose their cases correctly and say to them, you are not in a serious condition, then psychotherapy is of advantage.

Dr. F. B. Dorsey, Keokuk, Iowa: There is not a practitioner of medicine today who is not using psychotherapy to a greater or less degree, but there is a limitation to it. A short time ago I had a case of confirmed neurasthenia. A diagnosis of gall-bladder trouble was made, and the operation disclosed a gall-bladder full of stones. After these were removed the neurasthenia disappeared.

Dr. C. C. Goddard, Leavenworth, Kan.: The general practitioner chases dollars too hard to make accurate diagnosis. I find that when patients with neurasthenia are admitted into private institutions they have not been properly examined by the family physician. If they had been, the patients never would have been sent to such institutions, but treated at home. I think that pathologic conditions are at the bottom of the majority of cases of neurasthenia.

Dr. W. O. Henry, Omaha: The value of this paper lies in the fact that I emphasize the point that all physicians should employ psychotherapy. They should cultivate it as a means of diagnosis, but not to the exclusion of other things. Psychotherapy should be taught in medical schools. I believe that more attention will be given to it in the future than there has been in the past.

The Errors of Mind Healing.—Dr. R. Willman, St. Joseph, Mo.: The various healing cults are a danger to the human family. The dangers that follow in the trail of the pernicious practices of the healing cults may be summed up as follows: 1. The mind-healer being a non-believer in the existence of disease, its contagion, infection, etc., does not appreciate the necessity of knowing disease, and because of his unmindfulness of the danger of contaminating others, he leaves all gates open to the spread of disease. 2. The mind-healer has no idea of early diagnosis and proper treatment of disease when it is in its incipiency. Thus the patient is deprived of all opportunity to protect himself from danger and loss of life—things which early diagnosis and proper treatment could easily prevent.

Hemiplegia.—Dr. F. E. Coulter, Omaha, read a paper in which he reported a case of hemiplegia with acute onset. He also ex-

hibited the patient. He called attention to the salient points of practical importance in the management of such cases.

DISCUSSION.

Dr. C. R. Woodson, St. Joseph, Mo.: The mode of onset of lesions of the central nervous system is of more importance to the physician in making a diagnosis than anything else.

The Non-Surgical Treatment of Tuberculous Arthritis.—Dr. H. Winnett Orr, Lincoln, Neb.: Many patients who have old tuberculous sinuses would recover without operation in from six months to a year if carefully treated mechanically. Operative interference, even under the best conditions, prepares the way for mixed infection later.

DISCUSSION.

Dr. H. P. Hamilton, Omaha: Methods of extension and fixation are to be commended. If the disease begins in the epiphysis a different method of treatment than extension and fixation will be required. The important thing is to make the diagnosis early while the disease is in the epiphysis only. Usually, when the orthopedic surgeon gets the case, rupture has taken place into the joint, the ligaments and synovial membranes having already become involved in the inflammatory process, and then it is, and then only, the orthopedic surgeon should come in with fixation.

Dr. A. S. von Mansfelde, Ashland, Neb.: In order to be successful in these cases the surgeon should be a master in the use of plaster of Paris. He should also have a thorough knowledge of the action of the muscles.

The Neglect of the Sacroiliac Joint by the General Practitioner.—Dr. Edward Evans, LaCrosse, Wis., emphasized the anatomic importance of the sacroiliac joint, saying that its neglect in the diagnosis of painful and disabling conditions about the back and pelvis leads to improper treatment. He cited illustrative cases, and described the symptoms of strain of this joint, and then discussed the diagnosis and treatment.

DISCUSSION.

Dr. A. S. von Mansfelde, Ashland, Neb.: Men in throwing sacks of grain over their shoulders sometimes produce a partial dislocation of the sacroiliac joint which continues for years and is referred to as chronic nephritis, lumbago, or chronic rheumatism, when in reality nothing more than the dislocation of this joint, complete or partial, is the cause of the trouble.

Dr. H. Winnett Orr, Lincoln: I have seen two cases in which the sacroiliac joint has been strained in the manner described by Dr. Evans.

Dr. S. Grover Burnett: A lawyer sustained an injury in leaping from a street car. The hip joint seemed normal, but when any force was brought to bear on the pelvis, pain was intense along the scaroiliac joint.

Dr. F. B. Dorsey: A pregnant woman sustained a complete disarticulation at the symphysis and the right sacroiliac synchondrosis. Treatment consisted in placing her in the dorsal position and applying a plaster cast from a little above the waist-line down to and below the knee, immobilizing the knee and the hip. She made a perfect recovery.

Dr. Mary Strong, Omaha: Is the Walcher position, which is frequently used in cases of slight degree of contraction of the pelvic inlet, likely to injure the sacroiliac joint?

Dr. Edward Evans, LaCrosse, Wis.: If a patient be put in the Walcher position, high forceps applied, and the sacroiliac joint strained, one takes care of it afterward, but these slight strains, as a rule, are not cared for by practitioners.

Facts in Ophthalmology of Practical Importance to the General Practitioner.—Dr. John Monroe Banister, Omaha: It would be most advantageous to the busy medical practitioner in general practice to possess sufficient ophthalmologic knowledge to recognize the ocular conditions demanding immediate attention, and to acquire the small amount of skill necessary to give palliative treatment of such urgent affections until the services of a specialist can be secured.

DISCUSSION.

Dr. A. S. von Mansfelde, Ashland, Neb.: Eyes have been lost because the general practitioner has not realized the importance of an injury to the eye at the time the case was seen, and more knowledge on his part would enable him to deal with such cases successfully.

Dr. B. W. Christie, Omaha: Medical colleges should not graduate students without giving them an intelligent idea of the use of the ophthalmoscope They also should be taught how to refract.

(To be continued.)

To remove moles, apply with a splinter of wood, a small quantity of acid nitrate of mercury, carefully avoiding the sound skin.

MEDICAL MISCELLANY

The Pellagra Problem.—Passed Assistant Surgeon John D. Long, of the United States Public Health and Marine Hospital Service, has been detailed by Surgeon General Wyman to go to Columbia, S. C., and spend at least six months in the study of the pellagra problem in that State.

Physician Pardoned.—Governor Carroll of Iowa, upon recommendation of the State Board of Parole, has pardoned Dr. J. W. Crofford of Decatur county, who in 1905 was sent to the penitentiary for twelve years for the murder of a patient in his hospital at Lamoni. Newly discovered evidence showing that the man is innocent formed the grounds for the pardon.

Dr. J. Solis-Cohen Honored.—A testimonial dinner was tendered to Dr. J. Solis-Cohen, of Philadelphia, at the Union League Club, on the evening of March 15th, in honor of his having completed half a century of active service as a physician. On April 11th Dr. Cohen will be the guest of honor at the annual banquet of the Northern Medical Association, of which he was a former president.

The village of Vermillion, near San dusky, O., has taken sweet revenge for the death of its best-loved citizen, Dr. Frank Engelbry, who was run down and killed at a grade crossing recently. The mayor and council have demanded the abolition of four New York Central crossings, which the railroad company has finally consented to make, although involving an expenditure of nearly $500,000. The physician's death was not in vain if future fatalities will be avoided thereby.

Vaccination Statistics in Great Britain.—That Great Britain is yearly laying itself more open to the dangers of a great smallpox epidemic is evidenced by the rapid growth of the objection to vaccination in Great Britain as shown by the latest statistics. In the year 1906, 935,338 births were registered and the certificates of declarations of conscientious objections to vaccination numbered 52,391, or 5.6 per cent. In 1907 the certificates of objection amounted to 6.2 per cent of the births and in 1908 to 17.2 per cent. In the first six months of last year, 1909, they reached 18 per cent. The percentage of unvaccinated children yearly is even greater than these figures show, as the statistics quoted refer only to those who have not been vaccinated because of conscientious objections on the part of their parents.

Exit "Kissing the Book."—England's new Oaths Act abolishes "kissing the book." The disgusting practice has died a hard and lingering death. Even superstition is finding the cost of living too high for continued existence.

Dr. S. Weir Mitchell celebrated his eightieth birthday anniversary, February 15. A quiet dinner, at which a few of Dr. Mitchell's intimate friends were present, was given in the evening. All during the day he was the recipient of tokens of remembrance and congratulations from his many friends.

The British Medical Association will hold its seventy-eighth annual meeting in London, July 26 to July 29, 1910. The president's address will be delivered on Tuesday, July 26 and the sections will meet on the three following days. The annual representative meeting will be held on Friday, July 22, 1910. The address on medicine will be delivered by John Mitchell Bruce, M. D., F. R. C. P., of London, and the address in surgery by Harry Gilbert Barling, B.S., F.R.C.S., of Brimingham. The president of the association is Sir William Whitla and the president-elect Mr. H. T. Butlin.

Investment for Doctors.—It is seldom indeed that we have recommended any stocks for investment. The papers are full of advertisements, apparently plausible and honest, but which are in reality but speculative and uncertain in their nature. The doctors have been caught so many times in the past, that they are becoming wary, and refuse to invest their hard-earned dollars unless some guarantee or protection is thrown around their investment. A member of our staff had occasion to investigate a concern while in the east last summer and became so convinced as to its solidity and good management, that he not only invested his own surplus fund, but takes pleasure in advising his friends to do likewise. Reference is made to the International Fruit and Sugar Co., of Boston, an announcement of which will be found on another page of this issue. This company invites the closest scrutiny and investigation, and we would urge our readers to send for full information concerning this company's Cuba proposition, as it is worthy of the attention of all who are desirous of a safe, conservative and yet money-making investment. The plans and methods of this company will bear the search-light of investigation, and all inquiries will be promptly answered.

AMERICAN MEDICAL ASSOCIATION
meets in St. Louis, June 7 to 10.
"Come with us and we will do thee good."

THE MEDICAL FORTNIGHTLY

A Cosmopolitan Biweekly for the General Practitioner

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FAVORITE PRESCRIPTIONS

Oxaluria.—

I.

℞ Acid hydrochlor., dil .....ʒss
Tinct. ferri chlor.....ʒij
Syr. simplex.....ʒiiss
Aq.....ʒiij

M. sig.: A tablespoonful t.i.d. through a glass tube (with anemia and atony).—Hazard.

II.

℞ Strychniae sulph.....gr. j
Ac. phosphor., dil .....ʒij
Ext. erythroxylon fl., q. s. ad...ʒvj

M. Sig.: A teaspoonful t.i.d.—Christian, La Tribune Medicale.

Hysteria.—

℞ Tinct. castorei.....4 drams
Tinct. valerian.....1½ oz.
Aletris cordial Rio.....8 oz.

M. Sig.: Teaspoonful four times daily.

Itch.—

Mentholi.....grn. xj
Ichthyoli.....ʒiv
Calcii sulphurati.....ʒj
Sulphur .....ʒij
Lanolin .....
Ol. olivae.....aa ad ʒiij

Apply as required.—C. E. Boynton, in Southern Practitioner.

Lumbago.—J. J. Levy advocates (N. Y. Med. Journ.) the use of dry cups in lumbago, their application to be followed by the following, internally:

Potassii acetatis.....ʒss
Sodii salicylatis.....ʒii
Aquae gaultheriae.....ad fl. ʒiij

Teaspoonful in water every four hours.

Also this, to back:

Methyl. salicylatis.....fl. ʒj
Spiriti chloroformi .....fl. ʒss
Linimenti saponis.....ad fl. ʒiij

Rub in well for ten minutes, night and morning.

Balsam for the Treatment of Eczema.—According to the Bulletin general de therapeutique M. Griffon has employed at the Saint-Louis Hospital, Paris, a balsam of the following composition:

℞ Wood tar.....	parts	18
Ol. of cade.....	"	15
Resorcin	"	2
Menthol.....		
Guaiacol.....aa	"	5
Camphor.....	"	40
Sulphur-.....	"	15
Pulv. borax	"	36
Glycerin	"	54
Acetone.....	"	80
Castor ol.....	"	40
Hydrous wool fat.....	"	100

M. It is evident that the work of combining such a heterogeneous collection of drugs into a homogeneous balsam will call for more that ordinary skill. It is said, however, that the phenol compounds, e.g., tar, oil of cade, resorcin, guaiacol, etc., become associated in true chemical union with the camphor and menthol. The sulphur is obtianed by precipitation from a hot saturated solution in oil of turpentine, and is treated afterward with the mixture of tar, oil of cade, castor oil and wool fat, all heated in a closed vessel at a high temperature. The acetone forms the solvent and vehicle.—N. Y. Med. Jour.